NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NC VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

Registration District No. | Local No. 2011000001807 | BIRTH NO.

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)	2. DATE OF BIRTH (Month, Day, Year)	3. TIME OF BIRTH	4. SEX
*DEEN EMANUEL HALL-EL *	June 26, 2011	01:59 AM	Male

5. FACILITY NAME (If not institution, give street and number)	6. CITY, TOWN, OR LOCATION OF BIRTH	7. COUNTY OF BIRTH
Unc Hospital	Chapel Hill	Orange

FATHER

8a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	8b. DATE OF BIRTH (Month, Day, Year)	8c. BIRTHPLACE (State, Territory, or Foreign Country)
*WILLIAM SALAAM HALL-EL *	September 21, 1972	Alabama

MOTHER

9a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	9b. DATE OF BIRTH (Month, Day, Year)
*JASMINE CLARK HALL *	September 23, 1984

9c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)	9d. BIRTHPLACE (State, Territory, or Foreign Country)
*JASMINE CHANTELLE CLARK *	Colorado

10a. RESIDENCE OF MOTHER - STATE	10b. COUNTY	10c. CITY, TOWN, OR LOCATION
North Carolina	Guilford	High Point

10d. STREET AND NUMBER	10e. ZIP CODE	10f. INSIDE CITY LIMITS?
1589 Skeet Club Road Apt 102 Box 298	27265	☒ Yes ☐ No

11. MOTHER'S MAILING ADDRESS: ☒ Same as residence, or: State: City, Town, or Location:

Street and Number: Zip Code:

CERTIFIER

12. CERTIFIER'S NAME: SHELLA R RIGGSBEE (Electronically Certified)

TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE ☒ OTHER (Specify) Facility Birth Registrar

13. DATE CERTIFIED: 06 / 27 / 2011 (MM / DD / YYYY)

14. DATE REC'D BY LOCAL REGISTRAR: 06 / 28 / 2011 (MM / DD / YYYY)

15. DATE NAME ADDED: ___ / ___ / ___ (MM / DD / YYYY)

16. DATE AMENDED: ___ / ___ / ___ (MM / DD / YYYY)

NEWBORN

17. BIRTHWEIGHT (grams preferred, specify unit): 3317 Grams 7 Lbs.5 Oz. ☒ grams ☒ lb/oz

18. PLURALITY - Single, Twin, Triplet, etc. (Specify) Single

19. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)

RACE

20. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify)
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify)
- ☒ Other (Specify) Moor

21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify)
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify)
- ☒ Other (Specify) Moor

22. MOTHER MARRIED? (At birth, conception, or any time between) ☒ Yes ☐ No

IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No

23. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☒ Yes ☐ No

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

FATHER

24. FATHER'S SOCIAL SECURITY NUMBER: Unknown

25. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

- ☒ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American,
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)

26. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☒ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

MOTHER

27. MOTHER'S SOCIAL SECURITY NUMBER: 550-89-3670

28. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

- ☒ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American,
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (Specify)

29. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☒ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

30. PLACE WHERE BIRTH OCCURRED (Check one)

- ☒ Hospital
- ☐ Freestanding birthing center
- ☐ Home Birth: Planned to deliver at Home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's office
- ☐ Other (Specify)

31. FACILITY ID. (NPI)

32. ATTENDANT'S NAME, TITLE, AND NPI

NAME: SINA HAERI

NPI:

TITLE: ☒ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)

33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☒ No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

990086145

MOTHER

34a. DATE OF FIRST PRENATAL CARE VISIT: 01 (MM) / 10 (DD) / 2011 (YYYY) ☐ No Prenatal Care

34b. DATE OF LAST PRENATAL CARE VISIT: 06 (MM) / 24 (DD) / 2011 (YYYY)

35. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY: 8 (If none, enter "0".)

36. MOTHER'S HEIGHT: 5 Ft. 06 In. (feet/inches)

37. MOTHER'S PREPREGNANCY WEIGHT: 160 Lbs. (pounds)

38. MOTHER'S WEIGHT AT DELIVERY: 203 Lbs. (pounds)

39. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☒ No

40. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child): 2

40a. Now Living: Number 2 ☐ None

40b. Now Dead: Number 0 ☐ None

41. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

41a. Other Outcomes: Number 2 ☐ None

42. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes	OR	# of packs
Three months before pregnancy	0	OR	
First three months of pregnancy	0	OR	
Second three months of pregnancy	0	OR	
Third trimester of pregnancy	0	OR	

43. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
- ☒ Private Insurance
- ☐ Medicaid
- ☐ Self-Pay
- ☐ Other (Specify)

40c. DATE OF LAST LIVE BIRTH: 06 (MM) / 2010 (YYYY)

41b. DATE OF LAST OTHER PREGNANCY OUTCOME: 10 (MM) / 2008 (YYYY)

44. DATE LAST NORMAL MENSES BEGAN: 09 (MM) / 27 (DD) / 2010 (YYYY)

45. MOTHER'S MEDICAL RECORD NUMBER: 1509512-8

MEDICAL AND HEALTH INFORMATION

46. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/ intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment--If yes, check all that apply:
  - ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - ☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)
- ☐ Mother had a previous cesarean delivery
  If yes, how many _____
- ☒ None of the above

47. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☒ None of the above

Was mother tested for HBsAG? ☒ Yes ☐ No

If tested, include test date: 01 (MM) / 10 (DD) / 2011 (YYYY)

and test results: ☐ Positive ☒ Negative

48. OBSTETRIC PROCEDURES (Check all that apply)
- ☐ Cervical cerclage
- ☐ Tocolysis

External cephalic version:
- ☐ Successful
- ☐ Failed
- ☒ None of the above

49. ONSET OF LABOR (Check all that apply)
- ☐ Premature Rupture of Membranes (prolonged, >12 hrs.)
- ☐ Precipitous Labor (<3 hrs.)
- ☐ Prolonged Labor (> 20 hrs.)
- ☒ None of the above

50. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38°C (100.4°F)
- ☒ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment, or operative delivery
- ☒ Epidural or spinal anesthesia during labor
- ☐ None of the above

51. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☒ No

B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☒ No

C. Fetal presentation at birth
- ☒ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery (Check one)
- ☒ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean

If cesarean, was a trial of labor attempted?
- ☐ Yes
- ☐ No

52. MATERNAL MORBIDITY (Check all that apply)

(Complications associated with labor and delivery)
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☒ None of the above

NEWBORN INFORMATION

NEWBORN

53. NEWBORN MEDICAL RECORD NUMBER: 2000381-0

54. OBSTETRIC ESTIMATE OF GESTATION: 39 (completed weeks)

55. APGAR SCORE:

Score at 5 minutes: 9

If 5 minute score is less than 6,

Score at 10 minutes: _____

56. INFANT VACCINATION

Infant vaccinated with Hepatitis B vaccine?

☐ Yes ☒ No

If yes, include vaccination date

_____ (MM) / _____ (DD) / _____ (YYYY)

57. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than six hours
- ☐ NICU admission
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Congenital diaphragmatic hernia
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- ☒ None of the above

58. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft Lip with or without Cleft
- ☐ Cleft Palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☒ None of the anomalies listed above

59. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☒ No

IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____

60. IS INFANT LIVING AT TIME OF REPORT?
- ☒ Yes ☐ No
- ☐ Infant transferred, status unknown

61. IS THE INFANT BEING BREASTFED AT DISCHARGE? ☒ Yes ☐ No

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